MONTANA LEGISLATIVE BRANCH

Legislative Fiscal Division

Room 110 Capitol Building ? P.O. Box 201711 ? Helena, MT 59620-1711 ? (406) 444-2986 ? FAX (406) 444-3036

Legislative Fiscal Analyst
CLAYTON SCHENCK

Minutes
HJR 1 Subcommittee

September 17 and 18, 2001
Helena, Montana

The first meeting of the House Joint Resolution (HJR 1) Subcommittee was called to order by **Senator Bob Keenan**, Chairman, on September 17, 2001 at 1:00 p.m., in Room 102 of the Capitol Building. **Representative Bill Price** was elected Vice Chairman. The Subcommittee includes members of the Legislative Finance Committee (LFC); Legislative Audit Committee (LAC); Children, Families, Health, and Human Services (CFHHS); Law, Justice and Indian Affairs; State Administration; PRS; and Veterans Affairs. The following members were present:

Senator Keenan, Chairman	Representative Price
Senator Pease	Representative Jayne
Senator Cobb	Representative E. Clark
Senator Stonington	

Senator Franklin was excused.

HJR 1

Lois Steinbeck, Senior Fiscal Analyst, Legislative Fiscal Division (LFD), explained that HJR 1 (Exhibit 1), a study resolution, was an outcome of the HJR 35 study last interim. The goals listed in HJR 1 are the integration of services within the Department of Public Health and Human Services (DPHHS) and across all state agencies that serve adults with mental illness or children with serious emotional disturbances and adults or children with other coexisting disorders in cooperation with local governments and school districts. The following areas of concern are also included:

1) the continued development of appropriate and effective community services to serve persons in the lease restrictive environment;

2) the development of methods to ensure maximum leverage of federal funds, the cost-effective provision of services, and the use of best practices, including the evolution of more sophisticated case management;
3) the issues of commitment to community facilities, programs, and treatment and involuntary medication identified in the 1999-2000 interim process;
4) the interaction of mental health services and the courts and criminal justice and corrections systems in terms of training those who come in contact with persons with mental illness, diversion of persons with mental illness from the criminal justice system to mental health services, appropriate treatment in jails and prisons, local government responsibilities for transportation of persons with mental illness, the differences in the incidence of mental illness and the treatment offered to male and female inmates, and cost-shifting between state agencies for mental health services;
5) the structure and financing of mental health services available for veterans and the extent to which U.S. Department of Veterans Affairs resource allocation decisions may shift costs to state and local services and the consideration of options for mitigation the consequences;
6) children needing mental health services and the child mental health services system; and
7) other emergent issues regarding mental health services

Senator Stonington asked if the Subcommittee would ultimately be responsible for forming legislative policy for the mental health system or would that be the responsibility of the DPHHS and the Mental Health Oversight Advisory Council (MHOAC).

Senator Keenan responded that statutory changes would probably come from this Subcommittee.

Senator Stonington expressed concern regarding the Subcommittee receiving adequate knowledge and information to be able to assess proposed legislation.

Senator Keenan suggested that members of this Subcommittee have a roster, and be kept informed of what is happening in each of the committees.

Ms. Steinbeck explained that the study plan can be changed if it does not meet the needs of the Subcommittee. She also informed the Subcommittee that the meetings need to be completed by July or August in order for staff to complete any work in time for session. If this Subcommittee is the primary group for introducing legislation, the other committees have to potentially move up work schedules to get legislation to this Subcommittee for review.

Susan Byorth Fox, Research Analyst, Legislative Services Division, (LSD) relayed to the Subcommittee that it would be better to have draft language prepared earlier so there would be more time for debate. The Legislative Council will no longer request that DPHHS legislation be drafted. There is now a requirement that those requests go through interim committees.

Senator Keenan stated a letter from the Subcommittee would be sent to the other committees explaining that if endorsement from this Subcommittee is requested then draft legislation would be needed by June.

Serious Emotional Disturbance (SED) in Children

Dr. Hugh Black, Ph.D., clinical psychologist, Independent Practice, Helena, presented a handout (Exhibit 2) to the Subcommittee regarding treatment of children with SED. Dr. Black explained the differences in treating children who are seriously emotionally disturbed and adults who are seriously mentally ill. He discussed commonly believed falsehoods or mythologies, and children with dual diagnosis. He briefly explained the differences between children who are severely emotionally disturbed and children with problems. Dr. Black's opinion for a better system would be: 1) coordination of services; 2) family support; 3) early and thorough evaluation of children; 4) continuation of care: keeping kids from falling "between the cracks"; and 5) need for long-term planning and outcome measures.

Mental Illness - Adult

Dana Hillyer, Advanced Practice Registered Nurse in Psychiatric Mental Health, discussed severe and persistent mental illnesses that occur in adults. Her focus was on the neurobiological roots of mental illnesses and the brain functions that are disrupted when a person suffers from a major mental illness. Schizophrenia, major depressive disorder, bipolar disorder, obsessive-compulsive disorder and panic disorder were the major illnesses discussed. A copy of her testimony was distributed. (Exhibit 3).

Recent History of the Mental Health System

Ms. Steinbeck distributed a handout on the Mental Health System and State Agency Organization (Exhibit 4) summarizing recent highlights of the mental health system beginning

just prior to 1993. Prior to reorganization and managed care, Department of Social and Rehabilitation Services administered all Medicaid services except for children eligible through the foster care system or juvenile corrections.

In 1995 the new DPHHS was created, the new Department of Corrections received juvenile corrections functions, Department of Family Services was eliminated, and legislation was passed authorizing the development of a statewide managed care contract also know as the Mental Health Access Plan (MHAP).

In 1997 under reorganization, a new division was created within DPHHS and given responsibility and funding for all mental health services. DPHHS discontinued nearly all fee-for-service contracts and integrated state institutions into the managed care contract. The legislature eliminated $4 million general fund from the managed care budget request due to a double count in the executive budget.

In 1999, the human service appropriations subcommittee voted to eliminate the funding for the statewide managed care contract. DPHHS returned to a fee-for-service mental health system, and requested $19 million general fund supplemental for mental health services in the 2001 legislative session. The legislature approved the executive recommendation to: eliminate case management for children; eliminate partial hospitalization services provided in a nonhospital setting for children; reduce rates for partial hospitalization services; cap enrollment in the state funded mental health program; provide basic mental health services to about 100 children; limit expanded mental health services only for Medicaid and CHIP eligible children; and various funding switches. The legislature provided funds above the Executive Budget request for additional staff and accepted the executive recommendation to gradually implement a regional mental health managed care system.

Chuck Swysgood, Director, Office of Budget and Program Planning (OBPP)

Mr. Swysgood briefly talked about the HJR 35 Subcommittee during the 1999 biennium. Mr. Swysgood was the Chairman of that Subcommittee. He said that there are more needs than can be funded and some tough decisions will need to be made. The population at the Montana State Hospital (MSH) is a growing concern and one that can't be controlled. MSH is budgeted at 165

average daily population (ADP), which is up from the budgeted level of 135 last biennium. The MSH was under funded in the last biennium, which created the supplemental in the 2001 legislative session. Since the 2001 session, the MSH population has been around 175 to 179. Other driving costs are prescription drugs and the percent of federal poverty level funding. DPHHS is currently looking at costs associated with prescription drugs and is trying to get a handle on those expanding costs.

The DPHHS budget has more constraints on what can be done with the money than any other agency in state government. DPHHS is currently funded at approximately $275 million total funds for the biennium in the Addictive and Mental Disorders Division (AMDD), which includes approximately $105 million general fund; $13 million state special revenue and other funds; and $155 million in federal funds (Medicaid, CHIP, etc.).

Senator Cobb asked if DPHHS budget information would be available by July. Mr. Swysgood stated the OBPP will be in the EPP process in July and should have some idea of costs, and will have recommendations for the DPHHS.

Senator Stonington asked if the OBPP was implementing a more effective monitoring system to track funds and is it a new system. Mr. Swysgood stated that he is insisting on a more effective system with greater involvement of OBPP staff.

Dan Anderson, Administrator, Division of Addictive and Mental Disorders Division

Mr. Anderson distributed several handouts: 1) State-Funded Mental Health Service (Exhibit 5); 2) Montana State Hospital Average Daily Population (ADP), (Exhibit 5a); and 3) AMDD Phone List (Exhibit 5b). Mr. Anderson discussed three major issues DPHHS has dealt with in the last 10+ years in the mental health service: fragmentation of services; cost of services; and providing services in the least restrictive most integrated manner. In 1993 there were three different departments of state government providing part of the public mental health program. The three departments didn't coordinate very well with one another. To some extent they were using the same providers but often they would be buying services that were defined differently and paying different rates for the same services. In many ways it was a fragmented service. Progress has

been made on the fragmentation issue, nearly all mental health services are administered by one agency.

The mental health program has hired an Administrative Assistant, a new Bureau Chief and interviewed for a Regional Planner, however they did not have a suitable candidate. There are two or three other positions that are currently being advertised. DPHHS is not rushing to fill positions because of the 5 percent vacancy savings factor on all positions including direct care institutional positions.

Senator Cobb asked what new positions are being hired. Mr. Anderson stated a Regional Planner, a Budget Analyst, Law Enforcement Liaison Training, and Discharge Planner for the MSH. **Senator Cobb** also asked if DPHHS expenditures are exceeding it's budget now and if the money allocated for children is going to MSH. Mr. Anderson stated that the department is spending more mostly due to vacancy savings issue. Unless the MSH population decreases soon and stays down some of the money allocated for children will have to go to the MSH.

Susan Byorth Fox, Research Analyst, Legislative Services Division

Ms. Fox reviewed the Mental Health Bill Summary Exhibit 6). The summary does not include any appropriations bills or bills related to the X (Xantopoulos) Building. The X Building should be open in February for use as a DUI treatment center by the Department of Corrections (DOC).

The HJR 35 Subcommittee recommended 6 of the 13 bills that passed the 2001 session and members of the Subcommittee sponsored 12 of the 13 bills that passed. Of the bills that didn't pass, 2 had to do with community mental health centers: (HB 540) and (HB 566).

Public Comment

Several representatives from various associations offered comments to the Subcommittee regarding several issues. Comments were received from: Bonnie Adee, Mental Health Ombudsman; Mike O'Neill, AWARE; and Vicki Stall, LCPC, Great Falls.

Tuesday, September 18, 2001

The first meeting of the HJR1 Subcommittee reconvened on Tuesday, September 18, 2001, and was called to order at 8:10 a.m. by **Senator Bob Keenan**, Chair, in Room 102 of the State Capitol. The following members were present:

Senator Keenan, Chairman
Senator Pease
Senator Cobb
Senator Stonington
Representative Price
Representative Jayne
Representative E. Clark

Senator Franklin was excused.

Panel Discussion on Current Public Mental Health System

Participants of the panel were: **Mike McLaughlin, Ph.D**, Clinical Director of Golden Triangle Community Mental Health Center; **Peter Degel, Ph.D**, Clinical Director, Youth Dynamics Inc.; **Sandy Mihelish**, Consumer Advocate, NAMI; **Dan Anderson**, Administrator, Addictive and Mental Disorders Division, DPHHS.

Dr. McLaughlin explained how adults enter the public mental health system and how eligibility works for Medicaid and non-Medicaid clients. If the non-Medicaid individual does not meet the criteria of having a severely disabling mentally illness, he or she is not eligible for services unless it is a crisis and only until the person is stabilized. The non-Medicaid population can receive almost the full range of services as an individual eligible for Medicaid. The only exception is in inpatient treatment. The major difference in service is case management. Entry into the adult service varies according to whether an individual suffers from a severely disabling mental illness and the severity of the problem.

The largest source of referral is inpatient treatment from community hospitals. Other sources of referral are vocational rehabilitation (the age of onset is usually early 20's), physicians, law enforcement, homeless shelters, private therapists, and increasingly, chemical dependency providers. Half the individuals with severe mental illnesses also have chemical dependency problems and there has been a rapid rise in drug abuse, particularly methamphetamines. Five years ago most people in inpatient treatment were clients within the system, now less than half are new clients.

The state is currently funding pilot programs for integrated chemical dependency and mental health treatment. The PACT program (Program for Assertive Community Treatment) incorporates all aspects of treatment, from psychiatry to nursing, therapist, aides, vocational specialist and even chemical dependency counseling. The goal is to provide services that are as comprehensive as the services a client would receive in a hospital.

Senator Stonington asked if only some communities have the PACT program and is it publicly funded. Mr. McLaughlin said that it is publicly funded and there are two in Montana, Billings and Helena. The costs for PACT are more than the average cost for providing services throughout the system; however, the cost is much less than intensive inpatient or state hospital treatment.

Rep. Jayne asked Dr. McLaughlin how services are coordinated for an individual released from the prison system. Dr. McLaughlin sated that while an individual is in prison they are not eligible for services from the public mental health system but 45 days before release they do become eligible for case management services. It seems to be intermittent across the state as to whether case management referrals are being made and facilitated.

Dr. Degel discussed how children enter the system and distributed a chart on Services Covered By Publicly Funded Programs (Exhibit 7). There are three main sources in which referrals are received; 1) parents and family members; 2) other providers of services, physicians, private mental health providers; and 3) other public systems. The first step for children already in a treatment system is assigning a treatment team under the guidance and direction of a youth case manager. The team makes a determination as to what is the most appropriate service for the child based on his/her symptoms. If a child is new to the system, the youth case manager, with approval of the guardian, will begin the process of getting the child into the public system making sure of financial and clinical eligibility for services.

The children's mental health system is very complicated for agency personnel, parents and family members. Youth case managers struggle to make sure they use all the resources to the maximum amount possible.

Senator Keenan asked how a child receives case management services if the child is not eligible for services and has no insurance. Dr. Degel said the child would be referred to other services. One out of three referrals received directly from parents and physicians don't fit any program.

Senator Cobb asked if the system is so complicated because of the funding formulas or is there just not enough money. Dr. Degel said he feels it is both the funding formulas and lack of money.

Sandy Mihelish provided the Subcommittee with some history and education on mental illness. Ms. Mihelish is a member of NAMI Montana and the Program Director of NAMI Montana education programs. There are 220,000 members of NAMI and the majority have a serious mental illness. A new program to begin in Montana is a provider education program. It will involve training a team of 5 people: 2 family members; 2 consumers; and 1 provider with a family member with serious mental illness. This program is financially supported by the AMDD. Two other programs scheduled for consumers are: Living with Schizophrenia and Other Mental Illnesses, and Peer-to-Peer Education. These programs will teach consumers about their illnesses, limitations, abilities, and how to accept their illnesses.

These education programs are the key to eliminating the misunderstanding about serious mental illness and to reduce the stigma surrounding these illnesses. Contrary to what most of the general population believes, people with these illnesses cannot just pull themselves up by the "boot straps" and get on with their lives. These illnesses affect people between the ages of 16 to 25. NAMI estimates that 2.8 percent of the world population will get a serious mental illness. It can't be prevented and it can't be cured. In the last ten years, new medication has been discovered that not only treats the positive symptoms of mental illness but also the negative things that kept people from being able to be retrained at jobs, enter society and become productive citizens. Along with medication, effective counseling and effective psychotherapy are needed to maintain someone in the community.

Issues of concern are:

?? Lack of job rehabilitation, affordable housing, group homes, and work incentives.
?? Getting qualified for SSI and SSDI is a lengthy process and paper intensive.
?? Need improved insurance coverage.

?? Need more programs such as the PACT program.
?? Need earlier intervention to stabilize person before they become a danger to themselves or others.

Difficulties families have accessing the system:

?? Getting an accurate diagnosis is difficult.
?? Families of adults with mental illness are shut out of the system.
?? Services across the state are not uniform.
?? There is a break down in communication between treating physicians in the community and the treating physician in the inpatient facility or the treating physician in the jail or prisons.
?? Access to clinicians is difficult.

Dan Anderson discussed continuing challenges in trying to provide community based services as opposed to institutionally based services. Listed below are some examples of people being served at MSH that don't need to be served there.

?? Inappropriate admissions. A person with a drug and alcohol addiction and also a personality disorder that becomes a problem in the community when they are intoxicated.
?? Delayed discharges. A patient is kept until they have a reasonable discharge plan. Sometimes community programs are not ready or willing to take a person until they are more stable.
?? Forensics patients that don't need to be at MSH and sometimes stay for decades. They no longer require inpatient psychiatric services, but because of the criminal issues it is difficult and in some cases impossible to discharge them.
?? Geriatric patients that MSH has attempted to transfer to nursing homes, but families have objected, gone to court, and the judge required them to state at MSH.
?? Young patients with co-occurring chemical dependency or personality disorders have been in and out of the MSH many times. It is difficult to find programs to work with that patient on a discharge plan because they have created a lot of havoc in the communities.
?? Patient with low enough IQ to qualify for the state DD program. The DD program is a capped program with a limited number of slots. It is very difficult to get these patients into these slots. Generally they are competing with people already in the community and often in a crisis situation.

<u>Other issue - high-end of the children system.</u>

Out-of-home level placements

?? Residential treatment.
?? Therapeutic group care.
?? Therapeutic foster care.

Almost half of all the spending for mental health services, all Medicaid funding, adult and children, goes for youth in those three high-end levels of care. The mission for the SB 454 group is to look at the high cost children particularly those children with multi-agency needs.

SB 454 (Exhibit 8) created a multi-agency children's committee with representatives from all the agencies. The committee is reinvigorating the state level multi-agency agreement to determine how much still applies and/or what needs to be changed or added. Also, the committee is identifying high-end children and finding out what services were lacking in the communities they came from. The state agencies will work together blending funding or whatever it takes to create those services that could prevent some of these placements. DPHHS will have some proposals for the next legislature.

Request for Legislation

?? Certain forensics patients at MSH are not eligible for parole and probation if they are discharged. It would make it easier to discharge some patients if the presiding judge knows that not only will they be getting mental health services in the community, but parole and probation will be helping supervise their situation. This change would require a statutory amendment.
?? Conditional release from MSH – a person whose commitment has not expired can be discharged from the hospital only on the condition that he/she cooperate with the services in the community. Maybe all patients discharged on an involuntary commitment should have some period of time where they are on a conditional release. Such a change may facilitate providers agreeing to take consumers.
?? Gate keeping at MSH – The easiest adult mental health service to get into is the MSH which is the most restrictive There is no gate keeping mechanism by the MSH to be able to say whether or not an admission is appropriate.

Rep. Stonington asked how many patients have been at the MSH for decades, what is the average length of stay and is the hospital stabilizing the patient. Mr. Anderson responded that about 29 percent of the current patients at the MSH have been there for longer than a year. Most of those are forensic patients on criminal commitments. There is one patient that has been there since the late 70's. For most of the patients that are admitted today, the average length of stay is around 40 to 45 days. MSH is a place for people who need a longer period of time to stabilize and should not be used for long-term therapy. The goal is to get the person to the point where they can be back in a community program. The behaviors or symptoms that make it impossible for the patient to be served in the community should serve as the basis for a treatment plan in the

hospital. Addressing those issues will allow a person to get back into the community and that is where the long-term support and rehabilitation should take place.

Panel Discussion of a Recent Montana Supreme Court Decision

Participants of the panel were: **Greg Petesch**, Code Commissioner and Director of Legal Services, LSD; **Mike Menahan**, Lewis and Clark County, Deputy County Attorney; **Anita Roessman**, Montana Advocacy Program (MAP); **Peter Bovington**, Assistant Public Defender; and **Russ Cater**, Chief Legal Counsel, DPHHS.

Mr. Petesch summarized the case that was decided on August 2, 2001, titled IN THE MATTER OF THE MENAL HEALTH OF K.G.F. (Exhibit 8). This case was an appeal of a community mental health commitment that was based on an allegation of ineffective assistance of counsel. K.G.F. was voluntarily admitted to St. Peter's Hospital for treatment of bipolar disorder. After her admission to St. Peter's, she disagreed with the medication prescribed for her and refused to take the medication. Against medical advice, she requested that she be released. The county filed a petition with the District Court alleging a mental disorder that requires commitment. The petition relied on the findings and a request made by a case coordinator at St. Peter's Hospital who was also a certified professional person under state law. The primary focus and concern of the case worker was that K.G.F. planned to commit suicide and once released from the hospital that she would implement her plan. The petition also reported that K.G.F. was indigent and unable to afford an attorney, and that she was presently detained at the hospital. The petition requested K.G.F. be held at the hospital for further evaluation and treatment until a commitment hearing took place. On the same day the petition was filed, the District Court issued an order finding probable cause that K.G.F. had a mental disorder requiring commitment. Counsel was appointed and an initial appearance took place later that same day. A hearing was set for the next morning.

The court issued its findings of fact, conclusions of law, and order the day after the hearing. The court then issued an amended findings of fact, conclusions of law, and order. The court found that K.G.F. while at St. Peter's Hospital began to refuse medications and desired to sign out against medical advice. The court ordered that K.G.F. be committed to Golden Triangle Mental

Health Center for a period of 90 days for care, treatment and evaluation of the respondent's mental health needs.

The appeal was based upon an allegation of ineffective assistance of counsel at the hearing. The issue presented to the Supreme Court was: did K.G.F.'s counsel render ineffective assistance in violation of her rights guaranteed under the Sixth Amendment to the United States Constitution and Article II, Section 24 of the Montana Constitution? The court declined to adopt the criminal standard for effective representation. The actual holding of the case is that the right to counsel, which is a statutory right, provides an individual subject to an involuntary commitment proceeding the right to effective assistance of counsel. The court adopted certain provisions of the National Center for State Courts' Guidelines for Involuntary Civil Commitments. These guidelines are the minimal requirements that must be afforded for rendering effective assistance of counsel.

1) Appointment of competent counsel. To be eligible for appointment, attorneys should have specialized course training, or have received supervised on-the-job training in the duties, skills, and ethics of representing civil commitment respondents. The court also said, to provide the patient-respondent with clear and concise information describing the attorney's name and qualifications in order for the patient to then make an informed decision as to whether to accept appointed counsel, or to procure his/her own counsel.
2) The initial investigation. Counsel should conduct a thorough review of all available records. Such inquiry must involve the patient's prior medical history and treatment, the patient's relationship to family, friends and relevant medical professionals.
3) The client interview. Counsel shall meet with the respondent, explain the substance of the petition, and explain the probable course of the proceedings.
4) The right to remain silent. The patient-respondent has the right to remain silent. The client's right to remain silent potentially conflicts with the requirement that after the initial hearing the respondent must be examined by a professional person without unreasonable delay.

5) Counsel as an advocate and adversary. The court directed counsel to engage in all aspects of advocacy and to vigorously argue to the best of his or her ability for the ends desired by the client.

The court concluded the five guidelines are the general provisions governing a test for effective assistance of counsel, but they are not exhaustive.

Anita Roessman is an attorney for the Montana Advocacy Program (MAP), which is a private non-profit civil rights advocacy organization, comprised of six programs all federally funded and all governed by federal statute. Ms Roessman responded on behalf of K.G.F.

K.G.F. has a severe form of bipolar disorder. It is mixed and rapid cycling, which means her mania and depression occur together and her swings happen very quickly. Finding mixtures of medications that work is difficult and can take decades. There is no long-term stability for people with mental illness. Nothing works for everybody and for most people nothing works forever. To be completely safe, K.G.F. would have had to spend her adult life in a facility. K.G.F. has been married for 32 years and she raised two children who are now raising their own children and pursuing their professional lives. K.G.F. and her husband own a business together.

K.G.F. had a psychiatric crisis and voluntarily admitted herself to St. Peter's Hospital on October 21. On October 26 she got into an argument with her physician concerning medication and the side effects. Because K.G.F. resisted the medication and wanted to leave, the physician filed a commitment petition. Later that day K.G.F. was in front of a judge with an attorney she had never met. The morning after the preliminary hearing, K.G.F.'s civil commitment hearing was scheduled for 11:30 a.m. K.G.F.'s attorney had approximately 4 to 5 hours between the 2 days to prepare for the hearing.

The first witness for the public defender was an independent mental health professional who had examined K.G.F. and the second witness was K.G.F. There is no connection between what the mental health professionals said at the hearing and what the judge ordered. The judge committed K.G.F. to community services for 90 days and to a Helena facility until she was stabilized. She was also ordered to go to Golden Triangle in Helena for 90 days and an intensive case manager

would supervise her. An intensive case manager is someone who can help a person with mental illness negotiate his/her way through the maze of treatment, housing, employment, job training, benefits, etc. She was told she had to participate in Montana House programs as directed and to participate in outpatient therapy. She was placed under the care and direction of the chief medical officer at the Helena facility. She was told to cooperate with Golden Triangle for the term of commitment and the original order, which was later amended, said involuntary medication is necessary to protect the patient or the public or to facilitate effective treatment.

The judge invoked the power of the State of Montana to tell K.G.F. who her doctor would be and how she was going to deal with her mental illness. That experience had a profound effect on KG.F. and left her fearful in a way that she hopes this decision will help her overcome.

Mike Menahan, Deputy County Attorney, Lewis and Clark County, responded with the county's perspective of the K.G.F. case. Mr. Menahan believes this particular case represents how well the mental health system works and finds it distressing for the Supreme Court say in its decision that this case represents an obvious systemic failure of the mental health commitment process. Lewis and Clark County has an acute care psychiatric ward known as the support center at St. Peter's Hospital. The support center has six beds, a psychiatrist, full time nursing care, and it's a locked facility. Typically, people check in voluntarily, or police bring them, or referrals are received from the community, (e.g. PACT, New Visions, Hannaford House).

When the County Attorney receives a report from a mental health provider that says someone is mentally ill, a petition is filed. In nearly all cases they are detained at the support center, because if they are well enough to be in the community then they don't need a commitment. Petitions are filed only for people who are suicidal or who are a danger to others; or unable to take care of themselves.

K.G.F. was admitted in the support center and at the point in which she wanted to leave a report was sent to the County Attorney asking to file a petition. The petition was filed and the following day K.G.F. was evaluated by Carol Hand, Clinical Director of New Visions and K.G.F. agreed to go to New Visions. Although the commitments say 90 days, the reality is people are generally

referred to New Visions for a very short-term stay and once they stabilize they are free to leave. Mr. Menahan feels the purpose is to move people through the system as fast as possible given their particular circumstances. In the case of K.G.F. she was no longer suicidal after being in the support center. After the petition was filed she agreed to go to New Visions but she changed her mind sometime before the hearing and wanted to stay at the support center. Nancy McVain, Case Coordinator, said that K.G.F. was not appropriate for the level of care at the support center.

Mr. Menahan stated that since the K.G.F. decision people are staying at the support center much longer and more emergency detentions are being done by the state hospital. If the public defender asks for a continuance, it will delay the commitment, which will increase the cost to the county because it is responsible for all the pre-commitment costs. There will be a lot of people at the state hospital that don't need to be there. Also in the decision, it says the patient has a right to counsel during an evaluation and then likened an evaluation for the mentally ill to a civil deposition. None of the judges have seen a mental health evaluation and to liken it to a civil deposition is "ridiculous". It does not bear a relationship to what really happens at hearings.

Peter Bovington, Assistant Public Defender, was asked to discuss how this case would impact his job. Mr. Bovington explained that if he continues a case, and the support center is full or the doctors at the support center don't want to keep the client, he/she would then go to the state hospital. Most clients don't want a continuance because they don't want to go to Warm Springs. Another element of the decision that is problematic is the client's right to remain silent in the evaluation or the requirement that their attorney be with them during the evaluation. These evaluations can take place in an informal setting and are not always strictly scheduled. In the decision, it states that generally the court ordered examination serves to establish the evidence necessary for an involuntary commitment. Mr. Bovington has seen it just as often serve as what may be needed to either dismiss the case or to agree to a lower level of care. The right to remain silent or to not cooperate with the evaluation is telling the client not to talk to the person that could potentially get the case dismissed.

Russ Cater, Chief Legal Counsel, DPHHS, gave an overview of the departments' perspective. Mr. Cater has concerns that emergency placements will likely increase the state hospital population due to this decision.

Rep. Stonington asked Mr. Menahan what effect the standards will have on his job. Mr. Menahan stated that if a continuance is requested that may cause a shortage of local mental health facilities.

Sen. Stonington asked Ms. Roessman how will the standards help and why is that important. Ms. Roessman stated that this gives public defenders the luxury of asking for a continuance. Slowing the process down will mean that people actually stabilize and never get committed. This case highlights the inadequacy of community services. It draws attention to the fact that the foundation of a community system of care is the acute care services.

Mr. Petesch referred to the Statutory Overview of the Chronology of Commitment Procedure (Exhibit 10) that includes all the new statutes. This handout was prepared in the order that the process occurs rather than the order in which statutes appear in the code. It contains most of the statutes addressed in the case and in the footnotes.

Discussion of Roles and Responsibilities

SB 454 Work Group - Denise Griffith, Project Facilitator, Montana Children's Initiative (MCI), distributed a handout to the Subcommittee (Exhibit 11) outlining a chronological picture of the efforts that have been ongoing since the end of the legislative session regarding the children's initiative. In July, Dan Anderson submitted a draft process for defining the target population of children funded by AMDD, Child Family Services Division (CFSD), Office of Public Instruction (OPI), and/or Department of Corrections (DOC). In August, Candy Wimmer, State Coordinator, First Health Services, generated a list of children who meet the criteria. In September, MCI applied for a continuation grant from the Montana Youth Justice Council. On September 21, the fourth meeting was held and discussion focused on moving from planning to implementation. MCI will present a proposal to the Multi-agency Coordinating Committee (MCC) that outlines a plan for developing responsive provider networks in each of the targeted communities.

Senator Cobb asked how many children were on the list that meet the criteria. Ms. Wimmer stated there were approximately 150. The children who didn't fall in the criteria, but were in the top 50 most expensive cases are now included on the list. **Senator Cobb** also asked if the three communities have been identified, how many children will be placed in those communities and what are the timelines. Ms. Griffith stated that one community will be selected within each of the mental health service areas. Mr. Anderson stated that they hope to have the three communities chosen at the September 21 meeting and the process should be moving ahead by the end of this calendar year.

Senator Cobb asked if the money saved by not having children in high-end services will stay in the community. Mr. Anderson stated the money saved will be used to provide alternatives within the community.

Senator Keenan asked if a Medicaid waiver would be necessary for the pilot projects. Mr. Anderson stated that at this point they do not need a waiver.

Senator Cobb asked if other communities that don't get the project could sue the department. Mr. Anderson stated that he had not considered the possibility of being sued and that could lengthen the process of selecting communities.

Outcomes Work Group - Dr. Donald Harr, M.D. Psychiatrist, and member of the Mental Health Oversight Advisory Council (MHOAC) gave a brief overview of his testimony (Exhibit 12) on Performance Measurement Advisory Group (PMAG). PMAG will be responsible for the development and monitoring of performance and outcome indicators, measures, instruments, data collection protocols, and for assisting providers with obtaining and maintaining the resources necessary to meet the data obligations.

The Monitoring Committee will report to the MHOAC on activities developed by PMAG, progress being made and data findings. AMDD has asked the Committee to submit recommendations on service authority roles with respect to data collection and submission by providers.

AMDD recently submitted a grant application to Substance Abuse and Mental Health Services Administration (SAMHSA) for three years of financial assistance to reinforce, and if need be to, develop the data infrastructure in the Division to enable collection of needed data, process it and meet the federal reporting requirements necessary to report on 12 selected tables of information on an annual basis. Function of the Monitoring Committee and of the PMAG is to be complementary and not duplicative.

Olmstead Work Group - Marcia Armstrong, Consumer Liaison and Planner, AMDD, passed out a draft summary to promote community-based care that was submitted to the Center for Mental Health Services (CMHS) for approval (Exhibit 13). The membership of the Olmstead Committee consists of consumers, family members, advocates, MHOAC members and directors of the institutions. The Olmstead committee is the filter for the MHOAC and AMDD. Plans for the Olmstead Committee are:

- ?? Documentation of ongoing mental health issues that already are in compliance with the Olmstead decision.
- ?? Evaluation of statutes, policies and procedures related to institutions, including an examination of gatekeeping issues.
- ?? Identification of barriers, including cost shifting from mental health to corrections and from counties to the state and other issues related to the influence of funding mechanisms on decisions about how people are served.
- ?? Examination of what other states are doing.
- ?? Evaluation of solution options, including funding mechanisms and Medicaid waivers.
- ?? Protocols of identifying the people who will benefit from the Olmstead plan, including people in the institutions, people at risk for assignment to the institutions and people who are in the community but not integrated appropriately.
- ?? Recommendations that AMDD should include in the advice that it provides to the service areas.

The members present also agreed that development of the Olmstead plan should include a systematic public involvement strategy. (See Exhibit 14 for more detailed explanation.)

Mental Health Oversight Advisory Council - **Chairman Keenan**, MHOAC, gave a brief overview of the history of MHOAC and reviewed the responsibilities of MHOAC. MHOAC was established by SB 534 in the 1999 legislative session. Statutes require that at least half of the members be consumers. This interim it was decided that MHOAC would concentrate on helping AMDD develop the regional system. The Council approved a council structure comprised of four committees. The committees are:

- ?? Planning
- ?? System development
- ?? Finance
- ?? Monitoring

Chairman Keenan referred to the work calendar (Exhibit 14) for fiscal 2002 that includes tentative content/focus and meeting dates.

Senator Stonington asked Mr. Anderson to give a sketch of the regional system. Mr. Anderson explained that the state is divided into three geographic areas, east, west, and central. Created in each of those areas is a "service area authority", which is made primarily of mental health providers that serve that area. The providers would create a system or network of providers contracting with the "service area authority" to be responsible for the public mental health services in that area. The "service area authority" would have more flexibility in how it provides services but at the same time would be subject to some risk. There would be a certain amount of money the state would be paying for services and the "service area authority" would have to accept that dollar amount.

Senator Stonington asked what was the main driver behind going to a regional system. Mr. Anderson stated AMDD would like to get decisions on care managed at a local level. It wouldn't be possible to create managed care entities in every community, but roughly a third of the state is large enough and would involve the providers from that part of the state. The providers that serve people in that region would be responsible for care. The model would be based on some kind of capitated system. Mr. Anderson stated they hoped to issue planning guidelines by January to the service areas about what it is they need to do.

Ms. Steinbeck commented to the Subcommittee that a Medicaid waiver will probably need to be submitted. When a state opts into Medicaid they have to offer certain services statewide and there must be a freedom of choice among providers. If managed care is implemented in one region only, then it's not a statewide service and there must be a competitive bid if there is only one service provider.

SJR 5 - Sheri Heffelfinger, Research Analyst, Legislative Services, Division, is a research analyst for the State Administration and Veterans' Affairs Interim Committee that was assigned SJR 5 study. Ms. Heffelfinger gave a brief overview of SJR 5 Veterans' Study (Exhibit 15). A portion of the HJR 1 study is dedicated to Veterans' Affairs Services with regard to mental health. The primary study issues for the SJR 5 Subcommittee and the HJR 1 Subcommittee with respect to veterans relates to the mental health services and are as follows:

?? Program and funding priorities set by the federal Veterans' Administration (VA) may leave significant gaps in health care services for Montana's veterans, especially for mentally ill veterans.
?? There may be cost shifts to state and local service providers, especially with respect to the public mental health care system, including the Montana State Hospital and county emergency services. No funding has been authorized for contracted services to provide community based services for mental health and chemical dependency issues.
?? More strategic planning, service coordination, intensive case management, and communication is needed across federal, state, and local boundaries to ensure that mentally ill veterans have access the full spectrum of services needed without state and local governments shouldering costs that should be shouldered by the VA. This interagency cooperation and coordination is an acknowledged responsibility of the VA. SJR 5 study is looking for potential grant writing, to obtain federal funds, to help coordinate services. There is not a grant writing program in place to capture available federal funds from the VA. The Montana Veterans' Affairs Division has the authority in statute and has not used it except to build cemeteries. Montana does not have a homeless coordinator as many states do that are funded by the VA to coordinate the range of services for homeless veterans in Montana. The study will also look at the structure of advisory councils (MHAOC) to find out where the veteran representatives are on such councils.

Staff proposes that SJR 5 and HJR 1 Subcommittees work together to develop recommendations that will address these problems.

Senator Cobb asked for a list of recommendations, concerns, and specific options for review.

Sheri stated she would work with SJR 5 working group and come up with a list of recommendations. Recommendations will be finalized by March.

Public Comment

Representatives from various associations offered comments to the Subcommittee regarding:

- ?? Lack of adequate providers at every level.
- ?? Lack of incentives for providers.
- ?? Funding and developing peer-to-peer services, respite care, and out-of-home weekend crisis services.
- ?? Difficulty accessing mental health services for people in the criminal justice system.
- ?? Commitment law does not distinguish between child and adults. Children can be committed under the state law but there is no facility.

Comments were received from: Vicki Stull, Consumer, MHOAC member; Bonnie Adee, Mental Ombudsman; and Sally Johnson, DOC.

.

Ms. Adee distributed a letter from Gene Haire, Executive Director, Mental Disabilities Board of Visitors, (Exhibit 16), regarding concerns that the actual level of consumer need in Montana and the capacity of Montana's public mental health system have yet to be defined.

Draft Study Plan

Ms. Steinbeck referred to the Draft HJR 1 Study Plan (Exhibit 17), which outlines goals to accomplish at each meeting. The draft study plan is laid out in a series of proposed agendas for five meetings. The final section of the draft study plan lists suggested oversight topics that would be reviewed at each meeting. The draft meeting agendas allow for 1 to 1.5 hours of time for oversight. There are only three study meetings including today and the last two meetings are for issue identification analysis and review of options.

The second meeting reviews the service delivery system and funding and veterans' issues. The third meeting is a 2-day meeting and the 1st day would be in Helena and the 2nd day would be on campus at the state hospital. The fourth meeting is a one-day meeting to review issues and options, select final issues and options to be included in the final report and decide whether to

recommend statutory changes to the LFC. The final meeting will be to adopt final recommendations.

Senator Cobb suggested reviewing the proposed budget for the next biennium by the fourth meeting. Ms. Steinbeck stated that the kind of budget information that is typically available on the biennial budget would be the initial EPP proposals.

Senator Stonington suggested that the Subcommittee plan a tour of community facilities with attendance optional. The tour was scheduled for November 27th.

Standing Oversight Topics

Senator Stonington suggested a progress report from MHOAC and SB 454 work group half way through the interim and another report toward the end.

Direction to staff

- ?? Letter to other entities that this Subcommittee would like to review all proposed mental health legislation.
- ?? Questions regarding state hospital licensure and population in excess of licensure specific information regarding excess population.
- ?? What is status of four staff positions that were added by the appropriations subcommittee. Options from DOC about how to address mental health issues.
- ?? PACT report
- ?? Letter to Director Gray on how the Olmstead plan will be integrated, timelines and how and who is responsible

Tentative HJR 1 Subcommittee Meeting Dates

Wednesday, November 28th optional tour on 27th

Thursday, February 7th and Friday, February 8th.

Tuesday, May 14th.

The final meeting has not yet been scheduled.

Adjournment

Meeting adjourned at 4:05 p.m.

_____
Sen. Bob Keenan, Chairman

_____
Diane McDuffie, Committee Secretary